NO. 93-140

Supreme Court, U.S
FILED
JUL 08 1993
OFFICE OF THE C

IN THE SUPREME COURT OF THE UNITED STATES

October Term, 1993

JOHN W. CLEARY, KATHRYN M. CLEARY, et al.

Petitioners,

vs.

KAISER FOUNDATION HEALTH PLAN, CALIFORNIA, INC. et al.,

Respondents.

PETITION FOR WRIT OF CERTIORARI TO THE COURT OF APPEAL OF THE STATE OF CALIFORNIA, FIRST APPELLATE DISTRICT, DIVISION THREE

James E. Cooke
P.O. Box 1149
Larkspur, CA. 94977
Tel: (415) 461-8199
Counsel for Petitioners

QUESTIONS PRESENTED

1. Whether a state statute requiring an express provision for attorney's fee in an arbitration agreement prevails over federal statutory and common law requirements for award of attorney's fees to a successful ERISA[1] claimant?

2. Whether an arbitration provision in a HMO health plan requiring parties to bear their own costs and attorney's fee prevails over federal statutory and common law requirements for award of attorney's fees to a successful ERISA claimant?

3. Whether any tribunal determining an ERISA matter, even in a state system, must specify the reason a successful claimant is denied a requested award of attorney's fee and costs?

---

[1] The Employee Retirement Income Security Act of 1974, 88 Stat. 829, as amended, 29 U.S.C. § 1001, et seq.

4. Whether a state rule precluding judicial review of arbitration awards prevails over federal statutory and common law providing for review of denial of an award of attorney's fee and costs to a successful ERISA claimant?

5. Whether this Court should require state courts to exercise their concurrent jurisdiction consistently with federal law which protects the rights of successful ERISA claimants to an award of attorney fees and costs?

6. Whether the failure of the state court to address the ERISA issues presented to it constitutes a violation of the due process clauses of the Fifth and Fourteenth Amendments to the U.S. Constitution?

TABLE of CONTENTS

QUESTIONS PRESENTED i

PETITION FOR CERTIORARI 1

OPINIONS BELOW 2

STATUTE INVOLVED 2

STATEMENT OF THE CASE 3

REASONS FOR GRANTING THE WRIT 14

1) Innumerable, valid ERISA claims are precluded when confronted with state court restrictions on award of attorney's fees and expenses of arbitration and Pilot Life's prohibition against award of extracontractual and exemplary damages. 16

2) The issues present a clash between federal and state law which this court has previously indicated should be determined by federal law. 21

3) By ruling on the supremacy of the federal common law of ERISA over state law relative to the award of attorney's fees and costs, this Court can reduce a large and unnecessary burden on the federal court system. 23

a) ERISA's preemption of state law, in general. 23

b) Federal common law requires the award of attorney's fee and costs to successful ERISA claimants or a statement of "special circumstances" which would make such an award "unjust". 25

c) Arbitration of an ERISA claim should neither (i) forgo the right to an award of attorney fees; nor (ii) preclude judicial review for failure to recognize the right. 27

d) ERISA preempts state laws barring an award of attorney's fees and costs in arbitration. . . 29

4) Unless this Court declares the federal preemption of state bars to award of attorneys fees and costs, ERISA claimants must arbitrate or otherwise litigate their claims in the federal court system. 31

5) The failure of the state court to address the ERISA issues presented to it constitutes a violation of the due process clauses of the Fifth and Fourteenth Amendments to the Constitution. 33

CONCLUSION 34

TABLE of AUTHORITIES

Cases

	Page
Bird v. Shearson Lehman/American Express, Inc. (2d Cir. 1991) 926 F2d 116 . . .	28
FMC Corp. v. Holliday (1990) 498 U.S. 52.	24
Graphic Commun. Union No. 2 v. GCIU-EMP RETIREMENT (9th Cir. 1990) 917 F2d 1184	27
Hummel v. S.E. Rykoff & Co. (9th Cir. 1980) 634 F2d 446.	26fn
Massachusetts Mutual Life Ins. Company v. Russell (1985) 473 U.S. 134 . . .	20fn, 22
McDonnell v. MEBA Medical & Benefits Plan (9th Cir 1985) 759 F2d 1401	26
Menhorn v. Firestone Tire and Rubber Co. (9 Cir, 1984) 738 F2d 1496	26
Mitsubishi Motors Corp v. Soler Chrysler-Plymouth, Inc. (1985) 473 U.S. 614 . .	28
Moncharsh v. Heily & Blase (1992) 3 Cal. 4th 1.	8-11
Pilot Life Ins. Co. v. Dedeaux (1987) 481 U.S. 41	14, 18, 21, 24
Seamons v. Vaughan (11th Circuit, 1991) 921 F2d 1217	29-31
Texas Industries v. Radcliff Materials (1981) 451 U.S. 630	25

BEST AVAILABLE COPY

U.S. Constitution

	Page
U.S. Constitution Amendments V and XIV	33

U.S. Code

29 U.S.C. § 1001	i
29 U.S.C. § 1132	22, 23, 24
42 U.S.C. §§ 1395, 1396	4fn

California Code of Civil Procedure

CCP §1284.2	7, 30
CCP §1286.6.	9

Rules of Court

Calif. Rules of Court, Rule 976(b)	32fn

Other Publications

13 California Lawyer 40 (May 1993)	20

Petitioners John Cleary and Kathryn Cleary respectfully pray that a writ of certiorari issue to the California Court of Appeal, First Appellate District, Division Three, to review its judgment entered on November 25, 1992.

Petitioner Foundation for Health Care for Sonoma County (doing business as Redwood Health Foundations) supports the petition of the Clearys. "Redwood" is affiliated with the Sonoma County (California) Medical Society.[2]

---

[2]Two entities associated with Kaiser Foundation Health Plan and not named in the caption are: KAISER FOUNDATION HOSPITALS, a California corporation, and THE PERMANENTE MEDICAL GROUP, a California corporation.

No individual litigant is involved whose name does not appear in the caption.

OPINIONS BELOW

The unreported DECISION AND AWARD of the arbitration panel is produced at Appendix pp. 1 -17, infra.

The unreported order of the Superior Court confirming the arbitration award is produced at Appendix pp. 21-25, infra.

The unreported opinion of the Court of Appeal, First Appellate District, is produced at Appendix pp.26-51, infra.

STATUTE INVOLVED

29 U.S.C. § 1132 Civil enforcement

(a) Persons empowered to bring a civil action

A civil action may be brought -

(1) by a participant or beneficiary -

(B) to recover benefits due to him under the terms of his plan,

[and] to enforce his rights under the plan . . . .

(g) Attorney's fees and costs . . . .

(1) In any action under this subchapter . . . the court in its discretion may allow a reasonable attorney's fee and costs of action to either party.

STATEMENT OF THE CASE

Petitioners John and Kathryn Cleary are parents of Lisa who, as a ten-year old girl, developed anorexia nervosa.[3] Lisa's condition was treated by respondents' health maintenance organization (Kaiser). Thereafter, and on the recommendation of

---

[3] An eating disorder involving loss of appetite and resulting loss of body weight, to the extent that it becomes life-threatening. This condition is very unusual to occur in children under teen-age years.

Kaiser's treating staff, the Clearys determined that it was necessary to transfer Lisa to an institution which could properly treat her condition. A hierarchal Kaiser staff member refused to authorize payment, as provided in the Health Plan, to a facility which could provide proper treatment, so the Clearys were required to use $19,500 from their own resources, supplemented by Medicaid funds, to obtain proper care.

Petitioner Redwood supports the petition of the Clearys. Its claim for reimbursement of Medicaid ("Medi-Cal)[4] funds it paid for Lisa's care are pendant to that of the Clearys, and are not claimed to create grounds for certiorari. If the matter is remanded, then it is likely under California law that Redwood's

---

[4] 42 U.S.C. §§ 1395, 1396

claim may again be asserted.

For the purpose of this petition, the facts as set forth in the DECISION AND AWARD of the arbitrators are correctly stated. The same is generally true of the facts set forth in the opinion of the court of appeal.[5]

The arbitrators awarded the Clearys the $19,500 which they had expended, and also awarded them "their costs, including

---

[5] However, (1) the court's opinion fails to reveal that, pursuant to Kaiser's requirement that the matter be heard by three arbitrators, petitioners' costs of arbitration included $4,062 for "their" arbitrator and $5,250 as their one-half share of the charge of the neutral arbitrator; i.e., $9,112 in tribunal fees of their total arbitration cost of $13,750. (2) The referral to the arbitration panel was in no manner restricted to the claims as set forth in the complaint; the arbitration was conducted pursuant to briefs filed with the arbitration panel; and (3) The record reveals evidence of a nature which would have supported substantial extracontractual and exemplary damages against Kaiser. (See Appendix page 19, fn. 1.)

attorney fees unless barred or limited by contract or statute . . . ." (Appendix pp. 16-17, infra). The arbitration clause states that "'expenses of arbitration' do not include counsel or witness fees or other expenses incurred by a party for his or her own benefit", a mirror of the California arbitration statute which provides:

> Unless the arbitration agreement otherwise provides or the parties to the arbitration otherwise agree, each party to the arbitration shall pay his pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees or other expenses incurred by a party for his

own benefit. (Code of Civil Procedure §1284.2)

Kaiser moved to tax the Clearys' cost bill under an 4-page attack entitled "The Requested Award of Fees and Costs Is Barred by the California Arbitration Act and the Arbitration Agreement". The arbitration panel apparently bought this argument, for it then denied without comment, on a 2-1 vote, the award of any attorney's fee or cost whatsoever. (Appendix p. 18.)

In their motion to the Superior Court to vacate the award, in part for the panel's failure to award their attorney's fee, the Clearys asserted the award on the grounds of ERISA rights to attorney fees.(Appendix pp. 19-20, infra.)

The Superior Court made the summary response that the Clearys "cite no basis for recovery [of attorney's fee and costs]" and merely referred to the Health Plan (also known as the Service Agreement). (Appendix p.25, infra.)

On appeal, the Clearys extensively argued their rights to attorney's fee under the ERISA statute, the federal common law which developed that right, and even the ambiguity of the Health Plan agreement itself which should have been construed in the Clearys' favor. But all arguments were to no avail.

On July 30, 1992, between the date that briefing had been completed and oral argument herein, the California Supreme Court came down with Moncharsh v. Heily & Blase (1992) 3 Cal. 4th 1. In effect,

Moncharsh disapproved a long line of cases which permitted judicial review of arbitration awards where legal error causing substantial injustice appeared on the face of the award. With one exception, for the purpose of this petition, Moncharsh limited judicial review to the those available by statute, i.e., Code of Civil Procedure §1286.6. (See Appendix pp. 40-41, infra.) An exception was the availability of judicial review where:

> ". . . [G]ranting finality to an arbitrator's decision would be inconsistent with the protection of a party's statutory rights. (Accord Shearson/American Express Inc. v. McMahon (1987) 482 U.S. 220, 225-227 . . . Without an explicit legislative expression of public policy however, courts should be reluctant to invalidate an arbitrator's award on

> this ground. . . Absent a clear expression of illegality or public policy undermining [the] strong presumption in favor of private arbitration, an arbitral award should ordinarily stand immune from judicial scrutiny. (Moncharsh, supra, at 32; emphasis added.)

The Court of Appeal gave short shrift to the Clearys' claim for attorney's fee and costs under ERISA. Not a single reference is made to ERISA in the opinion despite extensive briefing on the Clearys' rights under the statute and federal common law. The opinion paid no heed to the clear expression of public policy in ERISA and its judicial constructions. The Court of Appeal merely found that since the arbitrators did not state on the face of the award the basis for their failure

to grant the Clearys' attorney's fee as originally awarded, then the award was not subject to judicial review under either Noncharsh or its predecessor rule. (Appendix pp. 50-51, infra.)[6]

In their petition for rehearing to the Court of Appeal, the Clearys stressed ERISA's preemption of the state bar against the award of attorney fees in arbitration and the federal common law requirement that an award which fails to award attorney's fees to a successful ERISA claimant must specify why the award was not made, and the right of review of award issues in federal court. The petition was denied.

---

[6] This approach is exactly the opposite of the federal common law of ERISA. As seen in the following section, such a failure to state the reason for not awarding attorney's fee and costs is itself grounds for judicial review.

The issues were again raised by the Clearys to California Supreme Court, but their petition for review was denied.

In addition to requiring the parties to bear their own attorney's fees and costs, Kaiser's arbitration clause interposes a solid economic barrier to the assertion of smaller claims against it by requiring claims be determined by a three-member panel, with each side employing its own panel member, and dividing equally the cost of the neutral arbitrator.

In this case, with medical testimony and other costs, a total of $13,750 of hearing costs had to be applied against their $19,500 recovery. After payment of their attorney's contingent fee, the Clearys recovered none of their hospitalization expense, and just a

portion of the interest value of that expense - which the arbitration panel found should have been borne by Kaiser.

The failure of the panel to award the Clearys their attorney's fee and costs of arbitration had profound economic impact. In fact, it rendered their "victory" purely pyrrhic. Without an award of attorney's fee and costs, even a claim of $19,500 makes no economic sense whatsoever to pursue.

REASONS FOR GRANTING THE WRIT

Petitioners, successful ERISA claimants, were awarded $19,500 in compensatory damages against their HMO, but the arbitration panel refused to award them any part of their $13,750 costs of arbitration (a substantial measure of which was created by the HMO's expensive arbitral scheme) or their attorney's fees. This clashes with federal law.

Petitioners were required to abandon their substantial extracontractual and exemplary damage claims against the HMO by reason of the ruling in Pilot Life Ins. Co. v. Dedeaux (1987) 481 US 41 at 54. On the other hand, the arbitral tribunal and all three levels of the state courts refused to recognize petitioner's right to award of attorney's fees and costs which were the explicitly provided counter-

balance available to them under ERISA.

In fact, the state appellate court refused to review the arbitrators' failure to award attorney's fees and costs because they failed to expressly state the grounds of their denial. The federal courts, on the other hand not only will review such failure, but will require such an award or, in the alternative, a statement of "special circumstances" why such an award was not made.

Petitioners' victory was rendered pyrrhic because the state court refused to recognize that ERISA preempts any state bar against the arbitral award of attorney's fees and costs. As the state court opinion and judgment stands, petitioners secure only their contractual damages under their ERISA coverage (no extracontractual damages) and are denied

their counterbalancing ERISA rights to attorney's fee and costs.

1) Innumerable, valid ERISA claims are precluded when confronted with state court restrictions on award of attorney's fees and expenses of arbitration [redacted] and Pilot Life's prohibition against award of extracontractual and exemplary damages.

A ruling of the Supreme Court is required to enlighten state courts on the federal common law of attorney's fee award standards for successful ERISA claimants. In this case petitioners experienced an entire panoply of adjudicators - from an arbitration panel to the state supreme court - which refused to even address, let alone recognize, federal common law developed on the subject. It is a clear example of exercise of concurrent

jurisdiction with state-law blinders. The state courts simply would not look beyond the apparent barrier of state law against awards of attorney fees in the absence of an express contractual proviso. This position is apposite to ERISA and its federal common law.

The magnitude of the issue is manifested by the fact that Kaiser, the respondent HMO, has 4,700,000 members in California and has an estimated 17,000 employer plans (hence the applicability of ERISA) in Northern California alone. Each has arbitration provisions similar to those at issue herein. Kaiser's barrier to keep this population of employee-members from asserting claims include its expensive arbitration procedure, enhanced by ERISA's prohibition of extracontractual and exemplary damages, finally battened

down with arbitral and state court preclusion of award of attorney fees and costs to successful ERISA claimants. Kaiser's barrier assures defeat against even the initiation, let alone prosecution, of all but the biggest money challenges to its caretaking procedures. Presumably Kaiser's perfected design of a near impenetrable barrier will be imitated by its competitor-HMOs if they have not in fact erected it already.

The need for protection under federal law arises, ironically, out of ERISA's limitations on damages. Under Pilot Life, supra, ERISA claimants have no right to extracontractual and exemplary damages which would otherwise be available to them under state law. This loss of rights is now being reflected in loss of legal representation for potential ERISA

claims. The problems confronting ERISA claimants were reviewed recently in the monthly publication of the California State Bar:

> Employees and policy holders subject to ERISA have little legal muscle when they go to court;
>
> The party that was supposed to furnish the benefit has a significant advantage, knowing that under ERISA it will not face punitive damage exposure and state tort claims are avoided;
>
> Every individual and corporation in America is liable for the payment of damages and even criminal prosecution, if it is found guilty of fraud - except for health insurers profiting from the ERISA loophole;

> The "you-can't sue-us-under-ERISA" defense has become ubiquitous, barring even actions for fraud.

As a result many plaintiff's lawyers rarely take ERISA cases anymore.[1] 13 California Lawyer 40 at 86-87 (May 1993; published by the Daily Journal Corporation in cooperation with the State Bar of California)

The significant consequence is the impact on potential ERISA claimants who would be unlikely to obtain skilled, knowing - if any - counsel willing to represent them.

---

[1] This result was not unexpected by this Court. See Mass. Mutual v. Russell set forth below.

2) The issues present a clash between federal and state law which this court has previously indicated should be determined by federal law.

In ERISA "Congress has enacted a comprehensive legislative scheme including an integrated system of procedures for enforcement." It precludes the award of extracontractual compensatory or exemplary damages under state law; otherwise the careful balance Congress' intended between fair claims settlement procedures and encouraging the formation of employee benefit plans would be undermined. Pilot Life Ins. Co. v. Dedeaux (1986) 481 U.S. 41, 55.

In answer to the concern that attorney's fees might present a barrier to maintenance of suits for small claims, thereby risking underenforcement of

beneficiaries' statutory rights, ERISA authorizes the award of attorney's fees. [29 U.S.C. § 1132(g)]. Massachusetts Mutual Life Ins. Company v. Russell (1985) 473 U.S. 134, 147.

Congress expected that a body of Federal substantive law would be developed by the courts to deal with issues involving rights and obligations under private welfare and pension plans. Accordingly, Justice O'Connor declared:

> Congress made clear its specific intention that all suits brought by beneficiaries asserting improper processing of claims under ERISA-regulated plans be treated as federal questions. . . The expectations that a federal common law of rights and obligations under ERISA-regulated plans would develop . . . would make little

sense if the remedies available to ERISA beneficiaries under [29 U.S.C. § 1132] could be supplemented or supplanted by varying state laws. (Pilot Life at 56; emphasis added.)

3) By ruling on the supremacy of the federal common law of ERISA over state law relative to the award of attorney's fees and costs, this Court can reduce a large and unnecessary burden on the federal court system.

a) ERISA's preemption of state law, in general.

ERISA's preemption clause is conspicuous for its breadth, establishing as an area of exclusive federal concern every State law that "relates to" an

employee benefit plan governed by ERISA. (FMC Corp. v. Holliday (1990) 498 U.S. 52, 58.) ERISA preempts "any and all State laws insofar as they . . . relate to any employee benefit plan, " except laws "which regulate insurance . . . ." (29 U.S.C. §1144(a), (b)(2)(A).)

Accordingly, this court has established that ERISA preempts state common law tort and contract remedies for improper denial of employee benefits when they "relate to" an employee benefit plan. (Pilot Life, supra, at 47-57.)

The statute in issue, 29 U.S.C. §1132(g) provides that "the court in its discretion may allow a reasonable attorney's fee and costs of action to either party."

The question presented now is whether ERISA also preempts state law restrictions on the award of attorney's fees and costs in arbitration proceedings.

b) Federal common law requires the award of attorney's fee and costs to successful ERISA claimants or a statement of "special circumstances" which would make such an award "unjust".

A federal court may develop federal common law where necessary to protect uniquely federal interests and where Congress has given the courts power to develop substantive law. Texas Industries v. Radcliff Materials (1981) 451 US 630 at 642.

There is a developing federal common law to provide the rights and expectations that ERISA brought into being, to supplement ERISA interstitially, and to develop standards ERISA only generally develops, and to develop principles to govern areas of law which were previously governed by state law. Menhorn v. Firestone Tire and Rubber Co. (9 Cir, 1984) 738 F2d 1496, 1499.

The federal common law of ERISA encompasses the principle that a consideration of the Hummel[2] factors will invariably lead to the conclusion that a prevailing beneficiary should recover attorneys fees. McDonnell v. MEBA Medical & Benefits Plan (9th Cir 1985) 759 F2d 1401, 1406. The exception would be a

---

[2] Hummel v. S.E. Rykoff & Co. (9th Cir. 1980) 634 F2d 446, 452.

"special circumstance" which makes an award of attorneys' fees unjust. Id.

Numerous cases under the federal common law of ERISA have required the trier of fact to provide reasons for an award or nonaward of attorney fees. See, e.g., Graphic Commun. Union No. 2 v. GCIU-EMP RETIREMENT (9th Cir, 1990) 917 F2d 1184 at 1189.

c) Arbitration of an ERISA claim should neither (i) forgo the right to an award of attorney fees; nor (ii) preclude judicial review for failure to recognize the right.

The anticipation that failure to protect a party's rights under ERISA would be subject to judicial review was expressed in the leading federal authority

permitting reference of an ERISA dispute to arbitration in Bird v. Shearson Lehman/American Express, Inc. (2d Cir. 1991) 926 F2d 116. It was based in part on Mitsubishi Motors Corp v. Soler Chrysler-Plymouth, Inc. (1985) 473 U.S. 614 which held that:

> By agreeing to arbitrate a statutory claim, a party does not forego the substantive rights afforded by the statute; it only submits to their resolution in an arbitral, rather than a judicial forum. 473 U.S. at 628; cited in Bird at 120.

Bird then held that arbitration would not conflict with Congressional desires for the establishment a federal common law of rights and obligations under ERISA-regulated plans. Id. at 122. Finally, Bird

observed that:

> . . .[A]n arbitration determination is subject to review by the federal courts through a motion to enforce or vacate the award. Id.

d) ERISA preempts state laws barring an award of attorney's fees and costs in arbitration.

This principle was recently demonstrated in Seamons v. Vaughan (11th Circuit, 1991) 921 F2d 1217, which involved claims by a trustee for beneficiaries consisting of professional wrecker operators against the administrators of a Health and Welfare Trust. The beneficiaries prevailed on basic claims of breach, and the arbitrators initially found the beneficiaries were entitled to their

attorney's fee, but deferred the determination to the district court. The district court awarded but one-half the attorney fees requested, explaining the reduction only by a "cryptic" handwritten comment relating to duplication of attorney services. Id. at 1220.

On appeal the administrators contended that Florida's attorney's fee provision in its arbitration statute, (which is similar in effect to California Code of Civil Procedure section 1284.2 provisions for payment of expenses and counsel and witness fees), precluded the award of the beneficiaries attorney's fee as there was no provision in the arbitration agreement for payment of attorney fees; and that Florida law should control the arbitration in this respect. The Eleventh Circuit held that an award of

attorney's fees were indeed required for the successful ERISA claimant, despite the state law prohibition and despite prohibition of such an award in the arbitration agreement:

> . . . This court specifically held that ERISA preempts state law breach of contract claims such as the one on which appellees prevailed in arbitration. (Citation.) The parties may not contradict federal law by private agreement. Thus, ERISA governs this case despite any provision [in the arbitration agreement to the contrary]. (Seamon, at 1219.)

4) Unless this Court declares the federal preemption of state bars to award of attorneys fees and costs, ERISA claimants must arbitrate or otherwise

litigate their claims in the federal court system.

The obvious fallout will be that attorneys who may, for some reason, accept ERISA claimant cases in the future will necessarily file in federal courts. Although there was no publication of the opinion below,[3] the plaintiffs' bar is not unaware of tides which the experience in this case surely represents.

It seems fair to assume that under present state court bars to award of attorney fees, if potential claimants can in fact get representation, then recovery efforts necessarily will be focused in the

---

[3] California rules provide that an opinion shall not be published unless it: (1) establishes a new rule of law . . .; (2) resolves or creates an apparent conflict in the law; (3) involves a legal issue of continuing public interest; or (4) Makes a significant contribution to legal literature . . . . Calif. Rules of Court, Rule 976(b)

federal courts.[4] No aware, skilled ERISA counsel would consider filing such a case in state court and face economic disaster, even if the case is won!

5) The failure of the state court to address the ERISA issues presented to it constitutes a violation of the due process clauses of the Fifth and Fourteenth Amendments to the Constitution.

Although diligently briefed, the trial, appellate and California Supreme Court all totally ignored petitioners

---

[4] The undersigned presently has pending another claim under health insurance acquired through employment therefore subject to ERISA, with probable referral to compulsory arbitration. Under present state law treatment of ERISA claims (no costs, no attorney's fee, no judicial review along with the federal exclusion of extracontractual and exemplary damages) there is a strong disincentive to filing in the state system.

claims for relief based on ERISA.

It is not easy to conceive of a clearer example of failure by a judicial system to render due process to a civil litigant.

CONCLUSION

For these various reasons, this petition should be granted.

Respectfully submitted,

JAMES E. COOKE
PO Box 1149
Larkspur, CA 94977-1149
Counsel of Record

APPENDIX

TABLE of CONTENTS

Page

Arbitrators' DECISION AND AWARD rendered 1/18/91 1

Arbitrators' ORDERS ON MOTIONS TO REOPEN AND TO TAX COSTS, 2/21/91 18

Extract from Clearys' REPLY TO OPPOSITION TO MOTION TO VACATE ARBITRATION AWARD,Etc. filed in Superior Court, 5/16/91 . . . 19

Superior Court's ORDER CONFIRMING ARBITRATION AWARD, filed 7/29/91 . . . 21

Opinion of the COURT OF APPEAL, FIRST APPELLATE DISTRICT, filed 11/25/92 . 26

Court of Appeal, Cleary v Kaiser, petition for rehearing denied, filed 12/23/93 . 52

Court of Appeal, "Redwood" v Superior Court, petition for rehearing denied, filed 12/23/93 53

Supreme Court of the State of California, petition for review denied, filed 2/10/93 54

ROBERT H. KRONINGER
Neutral Arbitrator
PO Box 500
Inverness, CA 94937

(415) 669-7382

IN THE MATTER OF ARBITRATION BETWEEN

JOHN W. CLEARY and KATHRYN M. CLEARY	)	DECISION AND AWARD
Claimants,	)	
v.	)	
KAISER FOUNDATION HEALTH PLAN INC., et al.	)	
Respondents.	)	

The above-captioned matter having been submitted on briefs and oral argument January 2, 1991, after evidentiary hearing conducted November 16, 1990, the arbitrators now render their DECISION and make their AWARD.

At times here relevant, claimants were "members" of respondent's "Health

Plan" pursuant to agreement through claimant John Cleary's employment with Pacific Telephone, as was their ten year old daughter Lisa in her capacity of "Family Dependent."

In early 1984 Lisa lost weight at a rate which alarmed her family, and she began to be seen as an out-patient by Kaiser staff, particularly a pediatrician and a psychiatric social worker. She continued to lose weight, raising fears for her physical well-being. But her rejection of food and other bizarre conduct, including suicidal gestures, led the attending staff to diagnose her case as one of anorexia nervosa and to feel she needed in-patient psychiatric care.

Kaiser's Martinez Hospital was its only available facility in Northern California with a psychiatric ward, but inquiry revealed that no one as young as

Lisa could be admitted here. The possibility of placement in a non-Kaiser psychiatric facility was discussed with the parents by attending staff, who suggested several specific outside possibilities, including Stanford Hospital. But outside placement was rejected -- by whom is unclear, though Anthony Rienzi, psychiatrist at Kaiser Martinez, testified that though he did not see Lisa until some days later, he made the decision to place Lisa in the pediatric ward of her nearest Kaiser facility, in San Rafael, after discussing her case with others.

She was admitted there on March 1, 1984, and treated according to a protocol developed by Dr. Rienzi. As the days passed, her condition had not improved but deteriorated, and the parents were distressed by her condition and by what

seemed to them to be a very punitive and severe approach to her problems. So, on March 8, acting unilaterally and against the wishes of Kaiser, they removed her from Kaiser and placed her in Stanford Hospital in a psychiatric setting for young people. After initial brief further decline, her physical condition improved, and after 52 days there she was then transferred to Kings View Center, an extended care psychiatric hospital, where she remained through September.

Total charges for Lisa's care at Stanford amounted to approximately $35,000 and at Kings View approximately $42,000. (The precise amount is difficult to ascertain, as the figures vary from exhibit to exhibit.) Of this, claimants were required to advance $19,500 as a condition of admission to Stanford, and Medi-Cal has satisfied some (also unclear)

portion of the balance. This proceeding was initiated to seek reimbursement from respondent Kaiser, pursuant to the arbitration provisions of the subject agreement.

Claimants rely on Section 3-L of the Health Plan "Disclosure Form & Evidence of Coverage" which, to the extent here relevant, follows in substance Section Q of the Health Plan Benefit Schedule, which provides:

> "If, in the professional judgment of Medical Group, a Member requires Medical or Hospital Services covered by this Agreement which require skills not available with Medical Group or facilities not available in Hospitals and Medical Offices, and Medical Group determines that it would be in the best interests of the Member to obtain care from another source in the Service Area, then, upon written referral by Medical Group, payment, in lieu of service benefits hereunder, is made for prescribed services within the coverage of this Agreement . . . "

Claimants urge, as they must, that Lisa required covered service which required

skills or facilities not available at Kaiser and that it was in her best interest to obtain care elsewhere. Such proof would establish breach of contract by respondent and entitle claimants to be made whole for losses thus sustained.

The proffered evidence was in sharp conflict on the care required by a ten year old girl suffering from anorexia nervosa.

Two Kaiser psychiatrists who had been remotely involved in Lisa's care, and one independent psychiatrist called as an expert, testified that a medical setting was more appropriate to an anorexic patient's needs, at least initially, and that psychiatric treatment serves no purpose with a patient who is physically debilitated. They opined that the pediatric ward at San Rafael Kaiser was adequate to treat Lisa's condition.

Opposed to each opinion, Kaiser records indicate that both Lisa's treating pediatrician and her psychiatric social worker felt that she needed psychiatric care. A psychiatrist highly qualified in treatment of anorexia testified unequivocally that the records reflect that the immediate cause of Lisa's admission to Kaiser was psychiatric -- her suicidal and other bizarre behavior -- that in any case of anorexia, though the weight loss, if severe enough, may make medical treatment urgent, psychiatric support is needed at the same time because motivation through behavior modification is essential to a weight gain protocol. Therefore, he said that a youth psychiatric treatment setting was not only the treatment of choice but the only appropriate response to Lisa's condition, and that if she had stayed at Kaiser she

would not have improved (she did in fact continue to lose weight) and even if her physical had improved, she would have needed in-patient psychiatric case which a purely medical setting, e.g., the San Rafael pediatric ward, could not provide. This view finds support both from Lisa's treating staff, as above referenced, and in the testimony of respondent's independent expert who said that when he had had the opportunity he had set up a specialized hospital unit for anorexic patients "with twenty-four hour a day total focus on the problems."

It appears that increased awareness of and interest in anorexia in recent years has resulted in a variety of treatment protocols, which are still being modified and refined, thus making difficult professional -- hence judicial -- decisions. While Dr. Rienzi's protocol

may have been appropriate for some Kaiser patients, on the conflicting evidence here presented we hold that claimants have sustained their burden of establishing by a preponderance of the evidence that Lisa required covered services which required facilities not available at a Kaiser facility and that it was in her best interest to obtain care from an outside source, It is also concluded that Stanford and Kings View were reasonable choices and made reasonable charges.

Respondent contends that, even assuming the above conclusion, for several reasons recovery must be denied or limited. It is urged that ERISA imposed a three year limitation on action; but we hold that it cannot have been the intent to reduce opportunities for redress and that the California four year statute for actions based on written contract

controls. Making this claim by filing suit on March 4, 1988, was within the prescribed time, as the breach -- failure to assume responsibility for payment for alternate facilities -- did not arise until Lisa was removed to Stanford. Moreover, claimants should not be penalized for having permitted Kaiser to attempt to meet Lisa's needs and for giving Kaiser the opportunity to appraise her condition during the March 1 - 8 period she was there.

By April 1, 1984, claimants' funds were exhausted, so they sought Medi-Cal aid to continue Lisa's care. As a condition of eligibility, Medi-Cal required that Lisa not be a member of the Kaiser Plan so, on April 1, claimants terminated her as a "family dependent" member beneficiary and Medi-Cal thereafter assumed financial responsibility for

Lisa's continuing care. Respondent contends that terminating her as a member terminated any right to care or contribution by Kaiser. Such a position cannot stand, as that termination was compelled by what we have now found to have been respondent's breach of its obligation, and a party may not be permitted to profit from its own wrong.

Respondent also points to Section N of the "Coverage - Benefit Schedule," dealing with mental health services, which provides for "short-term inpatient mental health services, 45 days of hospitalization ..." This provision appears to control the case at hand. Dr. Rienzi for respondent testified, however, that the 45 day limit is not always strictly followed and that, if a patient continues to be in acute need of continued care for a reasonably short time, Kaiser

would continue to provide care. Here, Lisa was at Stanford for 52 days and we conclude that had Kaiser had appropriate facilities in which she was being cared, she would have been served for the additional 7 days. Kaiser is therefore liable for expenses incurred throughout that period.

Claimants also seek, on behalf of Medi-Cal, compensation for the cost of Lisa's subsequent care and treatment at Kings View, under Section K of the Schedule, which allows

> "up to 100 days of prescribed Extended Care Services . . . at approved Skilled Nursing Facilities. Extended Care Services include nursing care, bed and board, physical, occupational, and speech therapy, medical social services, prescribed drugs and medications and medical supplies, appliances and equipment ordinarily furnished by the Skilled Nursing Facility."

Respondent offers two objections to obligation for extended care, both of

which have merit. First, even assuming that, as urged by claimants, Section K controls, those 100 days are authorized for "Skilled Nursing Facilities", while Kings View was a hospital, with physicians as well as nursing staff in attendance, and in fact much of the expense incurred there was for psychiatric professional care. The Plan's specification of "nursing" facilities for extended care, was doubtless intended to limit the kind of service, hence the exposure to expense, for which obligation would be accepted.

Second, the structure of the benefit schedule document shows that Section K was not intended to modify or extend the Section N "Mental Health Services" portion of the contract. This appears both from the fact that the sections are given equal status in the document's structure and from the fact that Section N provides that

any "day or night care" provided, up to 90 days, would be diminished by two days for "each day of hospitalization for psychiatric conditions received . . . pursuant to Section N-2(a)". Section N-2(a) is precisely the section under which we have held Kaiser accountable for 52 days of hospitalization. Thus, had Lisa been treated in a Kaiser facility, her yearly allowance of mental care inpatient services would have been exhausted before she went to any extended care mental health facility; the same must be held to be true of her time at Kings View.

Thus, reimbursement may be had only for the 52 days Lisa spent at Stanford.

The next question presented is whether in this proceeding we can only take cognizance of and compensate claimants' out of pocket losses, or whether we can and should take action as

to some of all of the Medi-Cal claims. The State of California Department of Health Services has filed a "Notice of Lien" in this matter, reflecting that Medi-Cal contributed $16,040.89 toward the total approximately $35,000 cost of Lisa's stay at Stanford. We reject respondent's contention that the lien is unenforceable in this situation, and have concluded that we must acknowledge and honor any claim the State may make for participation in the proceeds of our award; otherwise, claimants' right to be made whole would be in jeopardy.

AWARD

For all the foregoing reasons claimants are awarded and respondent is ordered to pay to them the sum of $19,500, together with interest at the statutory prejudgment rate from March 8, 1984 until paid. Respondent is also ordered to hold claimants and their counsel harmless against loss by reason of the State claim of lien and, in that connection, to satisfy any valid demand of the State of California Department of Health Services for such sum as may be required in reimbursement of expenditures on Lisa's behalf at Stanford only, less any such portion thereof as may hereafter be awarded as attorney fees.

Claimants are awarded their costs, including attorney fees unless barred or limited by contract or statute, all to be proven by cost bill served and filed not

more than seven days after receipt of this Award. Any motion to tax shall be served and filed within seven days after service and filing of claimants' cost bill.

January 18, 1991

/s/
ROBERT H. KRONINGER, Arbitrator

January 17, 1991

/s/
SARAH FRIESENDORF, Arbitrator

January 16, 1991

/s/
CHARLES S. HOLDEN, Arbitrator

Caption for the Arbitration Panel
(See Appendix p. 1, supra.)

ORDER ON MOTIONS TO REOPEN

AND TO TAX COSTS

The motion of [the Clearys] to reopen the above proceeding and to enter a different award is denied.

The motion of [Kaiser] to tax costs is granted, and all items of [the Clearys'] cost bill are denied.

February 18, 1991 /s/
ROBERT H. KRONINGER
Arbitrator

I DISSENT
February 21, 1991 /s/
SARAH FRIESENDORF
Arbitrator

February 20, 1991 /s/
CHARLES S. HOLDEN
Arbitrator

Extract from Clearys' REPLY TO OPPOSITION TO MOTION TO VACATE ARBITRATION AWARD, Etc., filed in Superior Court, 5/16/91:

4. Attorney fees should be considered by a successor neutral arbitrator.

Kaiser asserted the bar of ERISA to prevent the award of potentially substantially extracontractual damages.[1]

With ERISA's cleaver slashing damage possibilities, the prosecution of smaller

---

[1] Clearys' psychiatric expert, head of Langley Porter's equivalent program, enumerated 15 categories of errors by Kaiser in its treatment of Lisa, including Kaiser's: (a) recommendation of a therapeutic milieu, then failing to provide it; (b) failure to work with the family, undermining its confidence in the medical treatment which Kaiser did attempt; and (c) intentionally taking the risk that the Clearys would remove their daughter from its care to obtain proper hospitalization elsewhere.

claims becomes problematical. In fact providers of employer-paid health care services which in contracts of adhesion require arbitration through expensive three-member panels and prohibiting the award of costs, can by reason of self-created unfavorable economics for dispute resolution, virtually isolate themselves from challenge.

The availability of the award of attorney fees under ERISA was a ground for the U.S. Supreme Court in sustaining the ERISA preclusion of extracontractual damages. Mass. Mutual Life Ins. Co. v. Russell (1985) 473 US 134, 147.

KENNEDY P. RICHARDSON
ANDREW C. HOYE
Attorneys at Law
1970 Broadway, Suite 745
Oakland, California 94612
Telephone: (415) 451-6770

Attorneys for Defendants
KAISER FOUNDATION HEALTH PLAN, INC.,
KAISER FOUNDATION HOSPITALS, and
THE PERMANENTE MEDICAL GROUP, INC.

IN THE SUPERIOR COURT OF THE
STATE OF CALIFORNIA
IN AND FOR THE COUNTY OF MARIN
Case No. 13781

JOHN W. CLEARY and
KATHRYN M. CLEARY

Plaintiffs,

v.

KAISER FOUNDATION HEALTH
PLAN, INC., et al.

Defendants.

F I L E D
July 29,1991
County Clerk

ORDER CONFIRMING ARBITRATION AWARD

Plaintiffs John W. Cleary and Kathryn M. Cleary, having filed a petition to confirm in part, vacate in part, and to remand for hearing an arbitration award;

defendants Kaiser Foundation Health Plan, Inc., Kaiser Foundation Hospitals, and the Permanente Medical Group, Inc. having filed a cross-request for confirmation of the arbitration award; James E. Cooke appearing on behalf of plaintiffs; Andrew C. Hoye appearing on behalf of defendants; said petition and cross-request having been heard before the Honorable William H. Stephens on June 7, 1991; the Court having considered the parties' written and oral arguments and the Court's file herein, and good cause appearing,

IT IS HEREBY ORDERED THAT:

Plaintiffs' petition to confirm, in part, vacate, in part, and to remand for rehearing the decision and award of arbitrators is denied. Defendants' cross-request for confirmation of entire award is granted.

With respect to denial of recovery for costs of treatment paid be Medi-Cal, plaintiffs have failed to sustain their burden of showing that, as far as plaintiffs are concerned, the award is uncertain and should be vacated. Plaintiffs never clearly explain how the award contemplates "further litigation" by Medi-Cal to recover its costs incurred for Lisa's treatment and, even assuming that Medi-Cal must, in fact, instigate some further litigation or proceeding to collect on its lien, any such further action will in no way involve or prejudice plaintiffs who have been specifically held indemnified by Kaiser, to the extent expenses were determined due under the contract. The award is complete and certain, and addresses each of the issues submitted for determination. CCP §1283.4; Award, pages 3,6, and 8.

With respect to denial of recovery for costs incurred for Lisa's care at Kings View Hospital, it cannot be said that the arbitrators' construction of the contract on the basis that that institution does not meet the definition of a "skilled nursing facility" for which extended care services may be payable under the contract (Section K) "amounts to an arbitrary remaking of the contract between the parties." PG&E v. Superior Court (1991) 227 Cal.App.3d 51, 84. "Skilled nursing facility" is specifically defined in the contract as "an institution...which...is primarily engaged in providing skilled nursing care and related services." (Contract, Definitions, Section P, page 2, emphasis added.) The facts which the arbitrators found, and which we may not disturb upon review, were that Kings View "was a

hospital, with physicians (and nurses)" and that services provided were mostly for "psychiatric professional care." (Award, page 7.) The arbitrators' construction certainly falls "within the range of ambiguity, i.e. within the ordinary bounds of semantic permissibility." PG&E, supra, page 85.

With respect to denial of attorney fees, plaintiffs cite no basis for recovery. See Service Agreement, Interpretation, Section 8, Arbitration of Claims, page 8.

Dated: July 16, 1991

/s/ _____

William H. Stephens

Judge of the Superior Court

NOT TO BE PUBLISHED IN OFFICIAL REPORTS

IN THE COURT OF APPEAL OF THE

STATE OF CALIFORNIA

FIRST APPELLATE DISTRICT

DIVISION THREE

FILED 11/25/92

JOHN CLEARY, et al.,

Plaintiffs and Appellants, A054516

v. (Sup.Ct. No.

137811

Marin County)

KAISER FOUNDATION HEALTH PLAN,

INC., et al.,

Defendants and Respondents,

FOUNDATION FOR HEALTH CARE A055692

FOR SONOMA COUNTY, et al.,

(Sup.Ct. No.

Petitioners, 137811

Marin County)

v.

THE SUPERIOR COURT FOR
MARIN COUNTY,
Respondent:
KAISER FOUNDATION HEALTH
PLAN, INC., et al.,
Real Parties in Interest
_____/

John and Kathryn Cleary (appellants) appeal from a judgment pursuant to Code of Civil Procedure section 1287.4[2] confirming arbitration award against respondents Kaiser Foundation Health Plan, Inc., Kaiser Foundation Hospitals, and the Permanente Medical Group, Inc. (Kaiser), for damages for breach of contract to provide medical care and services to appellants. Consolidated with this appeal

---

[2] All further statutory references are to the Code of Civil Procedure.

is the petition for writ of mandate of appellants and Foundation for Health Care for Sonoma County, doing business as Redwood Health Foundations (Redwood), for an order that the superior court remand the entire matter for further arbitration on the issue of Redwood's entitlement to an award for amounts expanded on appellants' behalf. We affirm the judgment and deny the writ petition

FACTUAL AND PROCEDURAL BACKGROUND

Appellants were members of a Kaiser group health plan called "Group Medical and Hospital Service Agreement" (Health Plan). In early 1984, appellants' 10-year-old daughter, Lisa, was diagnosed with anorexia nervosa. A dispute arose between Kaiser and appellants over the nature, quantity, and quality of care Lisa required. Believing that Kaiser would not or could not provide the kind of care they

felt Lisa needed, appellants requested that Kaiser pay for alternative services at another qualified health care institution under the "PAYMENT IN LIEU OF SERVICE BENEFITS" section of the Health Plan.

Despite deterioration in Lisa's condition, Kaiser refused to authorize outside placement for her. After several days in in-patient treatment at a Kaiser facility, Lisa's condition had deteriorated. Appellants removed her from Kaiser's care and placed her in Stanford Hospital, where her physical condition improved. After 52 days, she was transferred to Kings View Center (Kings View), an extended care psychiatric hospital, where she remained for several more months.

The total charges for Lisa's care at Stanford amounted to approximately

$35,000; the charges at Kings View were approximately $42,000. Appellants were required to advance $19,500 as a condition of Lisa's admission to Stanford. Redwood contracted with the State of California, Department of Health Services (DHS) to act as a fiscal intermediary to provide Medi-Cal benefits. Medi-Cal, through Redwood, paid a portion of the balance. [3] DHS imposed a lien in the amount of $45,884.81 upon the proceeds or satisfaction of any judgment or settlement in favor of appellants.

In March 1988, appellants filed suit

---

[3] The arbitrators' decision and award states that the precise amounts spent on Lisa's care at Stanford and Kings View are "difficult to ascertain, as the figures vary from exhibit to exhibit." Of the total of approximately $77,000 charged by the two institutions, appellants advanced $19,500, "and Medi-Cal has satisfied some (also unclear) portion of the balance." According to appellants, the portion paid by Redwood for costs incurred in Lisa's treatment amounted to a total of $45,884.

against Kaiser in Marin County Superior Court, seeking contractual damages for alleged breach of the Health Plan agreement and for alleged violation of the covenant of good faith and fair dealing. The unverified complaint prayed for reimbursement of appellants' out-of-pocket expenditure of $19,500 plus interest at the legal rate; "release of liability to Medi-cal [sic] in a sum of not less than $85,000"; punitive damages of $100,000; and attorney fees. Kaiser's answer generally denied all allegations of the complaint and alleged as an affirmative defense, among other things, that the entire complaint was "subject to mandatory and binding arbitration in accordance with the arbitration provisions" of the Health Plan.

In April 1990, the parties stipulated to a stay of the action pending final and

binding arbitration of appellants' claims in accordance with the arbitration provision of the Health Plan. The matter was heard by a three-member arbitration panel, consisting of two arbitrators selected by the parties and a retired superior court judge sitting as the neutral arbitrator. After full briefing and a hearing, the arbitration panel ruled that Lisa required covered medical services above and beyond that available at Kaiser, that it was in her best interest to obtain such care elsewhere, that the costs incurred for this care at Stanford and Kings View were reasonable, that Kaiser had breached the Health Plan by refusing to reimburse the costs of such outside care, and that appellants were entitled to be made whole for the losses they had sustained.

The arbitrators awarded appellants

the entire sum of $19,500 which they had paid themselves, together with prejudgment interest from March 8, 1984, until paid. On the question of the amounts paid by Medi-Cal through Redwood, the arbitrators acknowledge the notice of lien filed by DHS, and ordered Kaiser to hold appellants harmless against loss by reason of the lien "and, in that connection, to satisfy any valid demand of [DNS] for such sum as may be required in reimbursement of expenditures on Lisa's behalf at Stanford only, less any such portion thereof as may hereafter be awarded as attorney fees." The arbitrators awarded appellants their costs, "including attorney fees unless barred or limited by contract or statute, all to be proven by cost bill served and filed not more than seven days after receipt of this Award."

Appellants submitted a bill for

costs, listing $11,249.80 in costs and $43,215 in attorney fees. Thereafter, Kaiser moved to tax attorney fees and costs, contending that appellants' requested award of fees and costs was barred by both the arbitration agreement in the Health Plan and applicable law. At the same time, appellants filed a motion with the arbitration panel to reopen the proceedings, asking that the arbitrators determine "the amount due for reimbursement for Medi-Cal payments to Stanford" and award such reimbursement to Redwood. The arbitrators denied appellants' motion to reopen, granted Kaiser's motion to tax costs, and denied all items of appellants' bill of costs.

On February 22, 1991, appellants' attorney made a demand on Kaiser for payment of the DHS Medi-Cal lien. On April 2, 1991, Kaiser responded, disputing

the statutory validity of the Medi-Cal lien, pointing out that any direct action for reimbursement of the Medi-Cal payments would be time-barred since more than six years had elapsed since they were paid, and offering to settle the Medi-Cal claim of lien for $1,604. Kaiser also stated that it would defend appellants against any attempt by DHS, Medi-Cal, or Redwood to enforce the lien and would bear full responsibility for payment of the entire lien if it was determined to be valid and payable by the courts. [4]

---

[4] The April 2, 1991, letter stated: "Lastly, should Medi-Cal or [Redwood] institute any legal proceedings against [appellants] or you in an attempt to enforce the alleged lien, please advise . . . so that [Kaiser] Health Plan can take whatever measures are necessary to defend against such proceedings, at [Kaiser] Health Plan's expense, and otherwise hold [appellants] and yourself harmless against the claim of line. In short, [Kaiser] insists that it be given the right to contest the validity of the alleged lien. If the courts determine that the lien is valid and payable, [Kaiser] will bear full

Kaiser made payment to appellants of $29,955, consisting of the $19,500 principal amount of the arbitrators' award to appellants together with prejudgment interest. Appellants, through their attorney, executed an acknowledgement of satisfaction of the arbitrators' award, stating that the award "has been fully paid and satisfied by [Kaiser] to pay [appellants] 'the sum of $19,500, together with interest at the statutory prejudgment rate from March 8, 1984 until paid.'"

On April 29, 1991, appellants petitioned the superior court to confirm the arbitration award in part, to vacate it in part, and to remand the matter to the arbitration panel for rehearing. In their petition, appellants asked that the arbitration award be confirmed except insofar as it denied recovery for Medi-

---

responsibility for payment of the same." Appendix p. 36

Cal's lien in the amount of $45,884.81, denied recovery of costs incurred for Lisa's care at Kings View, and denied an award to appellants of attorney fees. Kaiser filed a cross-petition for confirmation of the arbitration award. The trial court denied appellants' petition, granted Kaiser's cross-petition, and ordered judgment confirming the arbitration award in full. The trial court concluded that the arbitrators' award was complete and certain, in that it shielded appellants from any liability for or prejudice from the Medi-Cal lien; that the arbitrators' interpretation of the terms of the Health Plan with regard to coverage for the medical services provided to Lisa at Kings View was not arbitrary or unreasonable; and that there was no basis for recovery of attorney fees in the Health Plan or any other authority.

JUDICIAL REVIEW OF ARBITRATION AWARDS

Appellants raise two issues before this court: whether the arbitration award should have included a resolution of the Medi-Cal claim and an award thereon; and whether appellants should have received an award of attorney fees. The petition for writ of mandate that appellants and Redwood jointly filed raises the additional issue of whether the arbitrators erred in their interpretation of the terms of the Health Plan and argues that the arbitration award should be vacated for its failure to order reimbursement of expenses incurred at the Kings View facility. None of these contentions have merit.

In the recent case of Moncharsh v. Heily & Blase (1992) 3 Cal. 4th 1, the California Supreme Court held that an award reached by a private arbitrator

pursuant to a contractual agreement to arbitrate is not subject to judicial review except on the limited grounds set forth in sections 1286.2 and 1286.6; that an arbitrator's decision is not generally reviewable for errors of fact or law; and that, contrary to statements in several opinions of the Courts of Appeal, the existence of an error of fact or law apparent on the face of the award does not provide grounds for judicial review, even if it results in substantial injustice. (Id., at pp, 8, 11-13, 26-28, 33.)

Section 1286.2, which sets forth the grounds for vacation of an arbitration award, states in pertinent part: "[T]he court shall vacate the award if the court determines that: [¶] (a) The award was procured by corruption, fraud or other undue means; [¶] (b) There was corruption in any of the arbitrators; [¶] (c) The

rights of such party were substantially prejudiced by misconduct of a neutral arbitrator; [¶] (d) The arbitrators exceeded their powers and the award cannot be corrected without affecting the merits of the decision upon the controversy submitted; or [¶] (e) The rights of such party were substantially prejudiced by the refusal of the arbitrators to postpone the hearing upon sufficient cause being shown therefor or by the refusal of the arbitrators to hear evidence material to the controversy or by other conduct of the arbitrators contrary to the provisions of this title."

Section 1286.6 sets forth grounds for judicial correction of an arbitration award. It states in pertinent part: "[T]he court, unless it vacates the award pursuant to Section 1286.2, shall correct the award and confirm it as corrected if

the court determines that: [¶] (a) There was an evident miscalculation of figures or an evident mistake in the description of any person, thing or property referred to in the award; [¶] (b) The arbitrators exceeded their powers but the award may be corrected without affecting the merits of the decision upon the controversy submitted; or [¶] (c) The award is imperfect in a matter of form, not affecting the merits of the controversy."

We conclude that none of the appellants' contentions of error corresponds with the limited statutory bases for judicial vacation or correction of an arbitration award, and there are no other grounds for overturning, reversing, or remanding such an award. (Moncharsh v. Heily & Blase, supra, 3 Cal. 4th at pp. 23-24, 33.

FINALITY OF ARBITRATION AWARD

Appellants' first contention is that the arbitrators violated the statutory provisions governing arbitration because their decision and award allegedly failed to resolve all the issues presented and was therefore not final. Specifically, they argue that the matter must be remanded for clarification and correction because Redwood's Medi-Cal claim was not resolved.

Appellants cite section 1283.4, which provides that an arbitration award "shall include a determination of all the questions submitted to the arbitrators the decision of which is necessary in order to determine the controversy." They contend that the arbitrators; failure to provide an award to Redwood for the Medi-Cal expenditures constituted a ground for partial vacation of the award under section 1286.2, subdivision (e), as

"conduct of the arbitrators contrary to the provisions of this title" that "substantially prejudiced" the rights of a party.

The contention is meritless. In the first place, neither Medi-Cal nor Redwood were parties to the arbitration agreement or to the arbitration itself, and were therefore not entitled to submit any claims to the arbitrators. By statute, any party to an arbitration must be a party to the arbitration agreement pursuant to which the arbitration takes place. (§ 1280, subd. (e).)

Moreover, at the outset of this litigation, appellants stipulated to the submission to the arbitrators only of the claims set out in their original superior court civil complaint, which did not contain any claims relating either to Medi-Cal or to Redwood. The only claims

made in appellants' complaint and submitted to arbitration concerned their own out-of-pocket expenditure of $19,500, and their own potential liability to Medi-Cal for reimbursement of the expenditures made by Medi-Cal on appellants' behalf. In short, the issues before the arbitrators covered appellants' own personal claims only, including their protection from potential claims or liens by Medi-Cal. The arbitrators' decision and award clearly resolved all of the issues presented, by awarding appellants the full amount of their personal out-of-pocket claim, including prejudgment interest, and by ordering Kaiser to hold appellants harmless from any claim or lien by Medi-Cal against them.

Under applicable law, there was no error and no grounds for vacation or correction of the arbitrators' award on

this basis. Indeed, had the arbitration panel gone beyond the claims and the parties before them and actually made an award to Redwood or to Medi-Cal, it would have been exceeding its jurisdiction, rendering the award subject to vacation under section 1286.2, subdivisions (d) or (e), or correction under section 1286.6, subdivision (b).

ASSERTION OF MEDI-CAL CLAIMS

Appellants argue that they were entitled to assert Medi-Cal's claims in the arbitration, because they arose from the same underlying incident and were thus subject to arbitration at the same time. Citing the case of Holmes v. California State Auto. Assn. (1982) 135 Cal.App.3d 635, they urge that they have the right to claim reimbursement for Medi-Cal's expenditures on Lisa's behalf as part of their own claim against Kaiser.

Appellants acknowledged before the arbitrators that their "recovery in this action is limited to [their] claims for the funds they advanced, interest thereon and attorney fees," and that they "cannot benefit from funds advanced by Medi-Cal." Thus, appellants effectively waived any claim for reimbursement of Medi-Cal expenditures before the arbitration panel.

Moreover, under Moncharsh v. Heily & Blase, supra, 3 Cal.4th 1, this alleged legal error is not subject to judicial review. Appellants have not pointed to any error of law or fact apparent on the face of the award in this regard. Appellants' reliance on Holmes v. California State Auto. Assn. supra, 135 Cal.App.3d 635, to attack the binding decision of the arbitrators is precisely the kind of legal argument which the California Supreme Court held in Moncharsh

could not be made to a judicial tribunal. Even if appellants were able to demonstrate such a legal error on the face of the arbitrators; decision and award (which in any case they have not), and that this error caused "substantial injustice," this would not supply grounds for judicial review under Moncharsh. (Moncharsh, supra, at p. 33.)

Neither do appellants or Redwood allege that any of the express statutory grounds for vacation or correction of an arbitration award apply here. They cannot contend that the arbitrators exceeded their powers under either section 1286.2, subdivision (d), or section 1286.6, subdivision (b), in making the interpretation that they did. "It is well settled that 'arbitrators do not exceed their powers merely because they assign an erroneous reason for their decision.'

[Citations.] A contrary holding would permit the exception to swallow the rule of limited judicial review; a litigant could always contend the arbitrator erred and thus exceeded his [or her] powers . . . [¶] . . . [I]t is within the 'powers' of the arbitrator to resolve the entire 'merits' of the 'controversy submitted' by the parties. (§ 1286.2, subd. (d); § 1286.6, subd. (b), (c),) Obviously, the 'merits' include all the contested issues of law and fact submitted to the arbitrator for decision. The arbitrator's resolution of these issues is what the parties bargained for in the arbitration agreement." (Moncharsh v. Heily & Blase, supra, 3 Cal.4th at p. 28.)

COSTS INCURRED AT KINGS VIEW

In their petition for writ of mandate, appellants and Redwood present the alternative argument that the

arbitrators erred in interpreting the Health Plan and in applying applicable law to the issue of whether appellants were entitled to be reimbursed for the costs of Lisa's care at the Kings View medical facility. They contend that the arbitrators misinterpreted the Health Plan provisions covering extended care services in such a way as to deny any Health Plan coverage beyond the time period within which Lisa was cared for at Stanford Hospital.

This argument is subject to the same flaws as the others presented by appellants in their separate appeal. There is no contention that any of the statutory grounds for vacation or correction of an arbitration award are met here. Under these circumstances, this legal argument does not provide a basis for judicial review. Indeed, it would not

do so even if the alleged errors were discernible on the face of the arbitrators' decision and award, which they clearly are not. (Moncharsh v. Heily & Blase, supra, 3 Cal.4th at p.33.)

ATTORNEY FEES

Finally, appellants argue that they were entitled to an award of attorney fees under both the Health Plan and applicable federal law. The contention is again meritless.

The arbitrators' award denied appellants' request for attorney fees without stating whether they were denied on the basis of the Health Plan or on some other statutory basis, and without specifying any other alternative reasoning or grounds. It therefore cannot be determined from the face of the arbitrators' decision and award that the legal error now alleged by appellants

actually occurred. Thus, even under pre-Moncharsh law, appellants would have been barred from making this argument the basis for a request for judicial review and invalidation of the arbitration award. (Noqueiro v. Kaiser Foundation Hospitals (1988) 203 Cal.App.3d 1192, 1196-1197.) Under current law, it is if anything even more clear that there are no grounds for judicial review of the denial of attorney fees.

The judgment is affirmed. The petition for a writ of mandate is denied.

_____
Chin, J.

We concur:

_____
Merrill, Acting P.J.

_____
Werdegar, J.

COURT OF APPEAL OF THE STATE OF CALIFORNIA

IN AND FOR THE

FIRST APPELLATE DISTRICT

DIVISION: 3

CLEARY, JOHN W. AND KATHRUN M.
vs.
KAISER FOUNDATION HEALTH PLAN, ET AL.
A054516
Marin County No. 137811

BY THE COURT:

The petition for rehearing is denied

Dated: December 23, 1992
Filed: December 23, 1992 White, P.J.

COURT OF APPEAL OF THE STATE OF CALIFORNIA

IN AND FOR THE

FIRST APPELLATE DISTRICT

DIVISION: 3

FOUNDATION FOR HEALTH CARE, ETC., ET AL.
vs.
SUPERIOR COURT
KAISER FOUNDATION HEALTH PLAN, ET AL.
A056592
Marin County No. 137811

BY THE COURT:

The petition for rehearing is denied

Filed: December 23, 1992
Dated: December 23, 1992 White, P.J.

First Appellate District, Division Three,
No. A054516/A056592
S030557

IN THE SUPREME COURT OF THE STATE OF CALIFORNIA

IN BANK

JOHN C. Et Al., Appelants

v.

KAISER FOUNDATION HEALTH PLAN INCORPORATED Et Al., Respondents and Companion Case

---

Petition for review DENIED

Filed: February 10, 1993

Lucas
Chief Justice